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Experiences of nurse leaders in delivering care to youth victims of violence

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Abstract

Violence continues to take its toll on post-apartheid South Africa and the youth remain the most affected group in many communities. Research has either dealt with violence in isolation, or the youth affected by violence. Very little is known about the nurse leaders delivering healthcare to youth victims of violence. This study sought to explore and describe the experiences of nurse leaders in delivering care to youth victims of violence at a community health centre in Khayelitsha. A qualitative, descriptive, and contextual design was used. The accessible population was professional nurses (N = 40) taking the lead in influencing victims of violence in the community to wellness. Nine individual unstructured interviews were conducted until data saturation was reached. The findings of this study showed that nurse leaders experienced challenges in terms of under-preparedness, staff shortages, work load, verbal abuse, as well as victim-related factors. Participants also expressed some rewarding experiences, such as increased personal awareness, personal empowerment, victim empowerment, and job satisfaction. The study recommended that in-service training should be conducted for newly-appointed staff members with the purpose of preparing them for the challenges and expectations in the field of violence amongst youth in the community.

Keywords: Youth, nurse leaders, violence, community health centre, experiences.

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Introduction

Nurses are the first professionals at community health centres who assist victims of violence. South Africa has an unprecedented burden of morbidity and mortality arising from violence and injury, with an annual average of about 3.5 million citizens who seek healthcare as a result of non-fatal injuries; half of these injuries are caused by violence (Seedat, Van Niekerk, Jewkes, Suffla & Ratele, 2009). Prevention of crime and violence is, therefore, a national health priority in South Africa. The sustainable strategies for Long Island 2035 (Long Island Regional Planning Council, 2010) point out that healthcare workers are often exposed to situations of violence. The World Health Assembly declared violence a public health issue as far back as 1996, with countless people being injured and some suffering from fatal health consequences as either victims, or witnesses of

acts of violence (Krug *et al.,* 2002). During the lifetime of a person, as many as 75% of South Africans experience at least one traumatic event. These experiences are an astounding cumulative burden and drain on the human resources of the country (Williams *et al.,* 2007).

The Western Cape Province has also noted a high rate of traumatisation among the youth that originates from violence and violence-related trauma, especially in the Cape Flats and Khayelitsha where most of the metropolitan youth live (Samara, 2005). Violence is an insidious and usually deadly social problem and includes child maltreatment, youth violence, and elderly abuse – these occur at home, on the streets, and in public settings (Butchart *et al.,* 2004). For the purpose of this study, violence refers to the act(s) of force against another person. Victims of violence are people who have experienced one or multiple forms of either physical or psychological violence that lead to people becoming helpless and powerless (Hamber & Lewis, 1997).

Traumatised youths should be supported to regain proper functioning in society (Nader, 2010) and nurse leaders can assist by empowering the youth through well-designed nursing programmes and guidelines that enable greater autonomy (Blanchard, 2009). Professional nurses are trained in leadership and client care management to prepare them for contemporary issues in acting as leaders in nursing practice (Huber, 2013). Professional nurses also act as leaders at community health centres by solving problems related to the coordination and delivery of care to individuals and society (Huber, 2013).

Provision of care is important and has been specifically recognised as necessary in providing quality healthcare to victims of trauma (Fredheim *et al.,* 2011). Nurses are the first point of contact at primary healthcare facilities. In healthcare settings, a *nurse leader* is defined as a nurse practitioner in a position of authority, who inspires and influences fellow health professionals to cooperate in pursuit of a common goal, such as enhancing patient care of victims of violence. Leadership can either be formal when the healthcare organisation delegates authority, or informal when a leader earns authority (Sullivan & Decker, 2005). There is little known about the experiences of nurse leaders delivering healthcare to victims of violence.

Since the early 1980s, there has been increased concern about how this work environment affects professionals (nurse leaders, social workers, counsellors, mental health workers, and psychiatrists) who are working with traumatised youth victims of violence (Kanno, 2010). Studies show that these professionals could experience occupational stress symptoms while attempting to assist these victims (Bride, Jones & MacMaster, 2007) with secondary post-traumatic stress. This is an inevitable consequence of supporting patients who are victims of crime and violence (Bride, 2004).

This study aimed at exploring and describing the experiences of nurse leaders who cared for youth victims of violence who visited a community health centre in Khayelitsha, Cape Town. In this study, violence referred to physical abuse, bullying, robbing, sexual harassment, and physical coercion.

Methodology

Study area

The study was conducted at a community health centre in Khayelitsha, which provides primary health care and 24-hour maternity, accident, and emergency services. According to the 2013 South African crime statistics, Khayelitsha had the highest number of reported crimes for murder, sexual crimes, attempted murder, and assault with the intent to do grievous bodily harm (Hale, 2014).

Research design

A qualitative, exploratory, descriptive, and contextual design was used. Qualitative research gives a voice to those who have not been heard. It is a personal experience (Clark & Creswell, 2010). An exploratory design allows room for collection of information from spontaneous interactions and observations (Martin & Hanington, 2012).

A descriptive design provides a detailed description of the experiences of nurse leaders who have cared for youth victims of violence (Houser, 2011). The use of a contextual design assisted the researcher to gather extensive data for understanding, needs, intents, and processes (Margaria, 2010). The research method encompassed detailed data collection from the participants during nine individual unstructured interviews.

Population and sampling

Khayelitsha is one of the most violent settings in urban South Africa and the 2011 census indicated that more than half of its population are youths (Luyt, 2008). The accessible population consisted of nurses working at a community health centre in Khayelitsha (N = 40).

Purposive sampling was used to select nurse leaders. Only nurse leaders serving as professional nurses in formal positions of authority at the clinic; working at the clinic for more than a year; who had delivered healthcare to youth victims of violence (between the ages of 14 and 22 years) during the previous six months; were selected as participants. The sample size was determined on the basis of data saturation when no new themes emerged from the data (Brink, 2006).

Data collection

Individual unstructured interviews were conducted in a quiet room at the community health centre during March 2013. Interviews took about 45 minutes. Unstructured interviews gave participants the opportunity to express themselves more openly, allowing the opportunity for more probing (Flick, 2009). A voice recorder was used and observational field notes were taken on the responses of participants. A pilot study is important, since it informs the feasibility of a study and identifies any potential problem in terms of methodology (Thabane, Ma, Chu, Cheng, Afisi, Rios & Robson, 2010). Two individual pilot interviews had been conducted that revealed that no changes needed to be made to the research question on the interview schedule.

Trustworthiness

Rigour is associated with the value of research outcomes (Burns & Grove, 2005). Rigour, in this study, was measured by credibility, transferability, dependability, confirmability, and applicability (Lincoln & Guba, 1985). *Credibility* was achieved through prolonged engagement with the participants in the field. This study was *applicable* to a specific context of a community centre. *Transferability* was evident, since the findings in this study could be meaningful in a different setting (Macnee & McCabe, 2008), due to the thick description of the data. *Confirmability* was achieved by the research findings that were a product of the inquiry (Babbie & Mouton, 2001) and an audit trail (Fitzpatrick & Kazer, 2012). *Dependability* was demonstrated by the stability of data over time and conditions, since the researchers were trained in conducting interviews (Brink, 2006).

Ethical considerations

Ethical approval was obtained from the Senate Research Committee at the University of the Western Cape (clearance number 12/5/17), as well as the Department of Health in the province. Participants signed informed consent forms and an information sheet explained the rights to privacy during the interview, confidentiality in sharing experiences with the researchers, withdrawal from the project, and anonymity where names could not be linked to any findings.

Data analysis

Tesch's method (1990) of open coding was used for data analysis. A process was followed of examining raw data in the form of words, phrases, sentences, or paragraphs while assigning either codes or labels to these elements (Saldana, 2013). Firstly, the recorded interviews were transcribed. The researcher then

developed a data coding system and, with the assistance of an independent coder, the codes were finally linked to form themes, categories, and sub-categories. Data triangulation was achieved by considering data from interviews and field notes, in order to increase the study validity (Guion, Diehl & MacDonald, 2011).

Results

The results indicate five themes related to the research question (Table 1). This article focuses on the data analysis of Theme 1.

Table 1: Five themes derived at from the data analysis

Theme 1	**Theme 2**	**Theme 3**	**Theme 4**	**Theme 5**
Personal experience: Both challenging and rewarding	Emotive responses in relation to care delivery to youth victims of violence	Psychological impact on nurses delivering care to youth victims of violence	Coping mechanisms that are used by nurses who care for youth victims of violence	Nurses delivering care to youth victims of violence need support

Theme 1 elaborates on the challenging experiences of nurse leaders with youth victims of violence. Table 2 presents the emerging categories and sub-categories of Theme 1.

Table 2: Themes and categories of Theme 1

Categories	Sub-categories	
Challenging	1.	Victims:
	•	Socio-economic situation
	•	Violence and abuse
	•	Gangs
	•	Substance abuse
	•	Illiteracy
	•	Teenage pregnancy
	2.	Nurse:
	•	Under-preparedness
	•	Staff shortage
	•	Increased workload
	•	Rudeness, and verbal and physical abuse toward the nurses
Rewarding	•	Increased personal awareness
	•	Personal empowerment
	•	Victim empowerment
	•	Job satisfaction

The experiences of nurse leaders delivering care to youth victims were also largely related to the external working environment, the population distribution, level of literacy, and community resources.

Theme 1: Challenging and rewarding personal experiences

Caring for youth victims of violence is a personal experience. A *personal experience* refers to the process of generally observing, encountering, or experiencing things as they occur in the course of time, and the collection of past and present characteristics that epitomise a particular quality of a person (Collins English Dictionary, 2009). Most of the participants acknowledged that providing care to youth victims of violence had contributed to the persons who they were, as one participant said: *". . . I saw myself like as a person who has a passion né a passion of getting to know people, getting to know because beside knowing somebody it also help you to know who am I"*. Another participant stated: *". . . I don't know how to put it . . . but for me to be here and to work with them . . . err sometimes at the end of the day, I feel like that I have done something for the youth"*.

A *challenging experience* refers to any experience that requires great physical or mental effort to accomplish, comprehend, or endure (Collins English Dictionary, 2009). A participant stated: *"What I can say is that care for the youth, especially in this community for me is a challenge, is a challenge, there are so many challenges; gangsterism is a challenge, teenage pregnancy is a challenge, drug abuse is a challenge"*. The following quotation describes a challenge as experienced by a nurse: *". . . the worse thing is the DOAs* (dead on arrival) *the people who came dead, those whom I cannot help, they were gun shot and the they die on the scene, they were stabbed and then the die on the scene is what make me sad because if those people can come here alive it means that I can help them anywhere"*.

Sub-category 1: Challenges related to the youth victims of violence

- *Socio-economic situations of victims*

Violence happens more commonly in societies that are unequal and fragmented (Ugur, 2012). These conditions are also true for the Khayelitsha community. A nurse leader indicated: *". . . they just go around, some follow the sun when it goes to another direction they follow to the other direction because there is nothing that they can do"*. While some of the youths try to empower themselves by acquiring education and realising their potential, the majority resort to what they call the *ikasi* style, which refers to ways in which youths try to rationalise their participation in unacceptable behaviour with the view of creating a sense of belonging. This comprises sex, violence, as well as alcohol and substance abuse (Swartz, Harding & De Lannoy, 2012).

- *Violence and abuse*

The Khayelitsha settlement is no exception to the experience of everyday violence, with many of these instances occurring in public places where people conduct their daily activities (Ugur, 2012), for example, schools, streets, as well as areas of entertainment (such as shebeens). A participant stated: *". . . shebeens. . . you see, it all starts there. . . its where they enjoy themselves and the fight starts there and they will come here* (sigh) *pause. . . because maybe they are stabbed on their way back from work or school"*.

With the omnipresence of violence, people feel very insecure wherever they are or whatever they are doing. According to the participants in the study, there are lots of instances of violence in the area, especially during weekends and in cases where people have part-time jobs, or where people get paid either weekly or fortnightly. A participant stated: *". . . especially weekends they are drunk, so the most cases honestly they are drunk. . . the weekend is like two times what we see in the week. And always there is a stab and gunshot here and there"*. Young girls especially become more vulnerable: *". . . we have to attend a client that is out, out, out, a person that doesn't even know that she is been raped, the amount of alcohol that has been consumed by the client, it demotivates me, it kills me because most of our young clients, or young female clients when they are raped, it's either they were drunk or it's either they were at a party"*.

- *Gangs*

Gangsterism is one of the challenges facing youths in this community. Allen (2009) points out that a gang presents a powerful challenge to emergency departments. When one member is injured, the other members follow that member into the emergency department. Once they are in the community health centre, some of these gang members even threaten the very nurses who are attending to them: *". . . some are coming with gun*[s]*, threatening that* [I] *am going to shoot you if you don't see my friend. . . they come here with their colleagues or whatever, and they shout the whole place"*.

- *Substance abuse*

From the narratives provided by nurses, most cases of victims seeking treatment at the community health centre are related to alcohol abuse. Either victims arrive there drunk, or they have passed out and are unable to recall a single event related to the traumatic experienced: "*We. . . we have to attend a client that is out, out, out, a person that doesn't even know that she is been raped, the amount of alcohol that has been consumed by the client"*.

- *lliteracy*

A study by Ackerson, Kawachi, Barbeau and Subramanian (2008) suggests that the level of education is an independent determinant of partner violence. Participants ascribed the inability of individuals to distinguish between genuine love and getting battered by their partners to the lack of education. A participant mentioned*: "Most of them, they are dropouts from school. . . also. . . some women think that if someone abuses them it means that the person cares for them and the person loves them. . . and when you say you love somebody, what does that mean? And when you say that you care for somebody, what does that mean? You know because it seems as if love is interpreted in a negative manner".* Literature supports the belief that illiteracy, like unemployment, is a factor that marginalises the youth, and it makes some of them vulnerable to exploitation and involvement in criminal and deviant behaviour (Adedokun, Osakinle & Falana, 2010).

- *Teenage pregnancy*

Teenage pregnancy is an international problem with South Africa and other countries experiencing an increase in teenage pregnancy while many of these teen mothers-to-be are still at school (James, Van Rooyen & Strumpher, 2011). Participants stated: *". . . because youth have a lot of challenges, né* [sic]*, there is teenage pregnancy"* and *". . . they are falling victims of pregnancy"*. Teenage pregnancy has subsequent health and social outcomes due to unemployment, poverty, and discrimination (Harden, Brunton, Fletcher & Oakley, 2009).

Sub-category 2: Challenges related to nurses and care, regarding youth victims of violence

- *Under-preparedness*

According to a participant, she did not really understand the treatment of victims of violence, hence it was challenging working with youth victims of violence: *". . . my motivation for doing nursing was because I was always interested in what are the nurses and the doctors doing to someone who is sick, I never thought about care delivery for youth victims of violence. I don't know why I never think about it, but I was concentrating on what are they doing on someone who is sick that is why most of the time I did not know what is the different between someone who is sick and someone who is a victim of violence"*. Therefore, nurses feel obliged to perform this task – to deliver care to youth victims – on a daily basis. This caring is not only physical, but emotional as well, and sometimes with psychological impacts for which they have not received formal training (French, Du Plessis & Scrooby, 2011).

- *Staff shortage*

According to Oulton (2006), nursing shortage is defined as the imbalance between demand for employment and the available supply. Nursing shortage is a global issue that impacts on the health systems around the world. An inadequate number of staff members not only puts the patients at risk, but also has a negative impact on the wellbeing of the nurses (American Nursing Association, 2007). A participant mentioned: "*Sometimes you feel guilty because one other day there were four resusces* [sic] (resuscitations) *here and there were four nurses that must resus* [sic]*, so we resus* [sic] *them and the other one resus* [sic] *this side and the other one we just put the drip on they have to wait until".*

- *Increased workload*

Increased workload refers to volume and level of nursing services (Morris *et al.,* 2007). A participant stated: *"There is* [a] *short*[age] *of equipment and the heavy workload, we see many patients. The youth passes* [Michael] *Mapongwana Clinic and also now there is big hospital in Khayelitsha, they pass the hospital and come straight to us. Feel like as if the work load now, they are adding on me because they are supposed to be helped that side, so those situations they also make me to feel like what are we doing here, why we have to have more work".* Bégat Ellefsen and Severinsson (2005) confirm that the less time a nurse has to complete a task, due to workload, the more physical symptoms of stress are evident or experienced.

- *Rudeness and abuse towards nurses*

Abuse refers to people who are screaming at somebody, calling one names, or threatening other people (Nazarko, 2007). A participant stated*: "Most of the patients are coming. . . are coming with rudeness sometimes, I can say rudeness. They shout the whole place, but we didn't talk to them like that we just calm down. So, we manage to see all the patients, all kinds of behaviour we see here".* This quotation reflects on the ability of nurses to interpret a situation and the need for nurses to have the necessary skills to manage rudeness appropriately. Furthermore, these circumstances also affect the nurses' ability to provide quality care, because they are a source of stress for nurses (French *et al.,* 2011). Another participant mentioned: *". . . most of the youths are rude, most of the times. They will shout at you, maybe it's not the patient but the escorts. Even* [when] *you are busy on the other side, they don't care about that they. . . hmmm. . . so they shout at you".* Abuse at the workplace decreases job satisfaction, causes low self-worth and burnout, as well as compels nurses to quit their job in response to repeated verbal abuse (Truman, Du Plessis & Scrooby, 2013).

Category 2: Rewarding experiences of nurse leaders delivering care to youth victims of violence

Participants confirmed that working with youth victims of violence was not only challenging but was also fulfilling. They pointed out that the opportunity to treat those victims made a valuable contribution to their lives and they considered those health interventions as rewarding.

- *Increased personal awareness*

Self-awareness is an inwardly-focused evaluative process during which individuals make self-standard comparisons with the goal of better self-knowledge and improvement (Greg & Roni, 2012). Participants indicated that they became more aware of themselves and the world of the victims and, hence, their view of health, illness, and victims of violence changed: *"It is a passion of getting to know people, getting to know because besides knowing somebody it also helps you to know who am I"*; *"It gives you opportunities to self-reflect and try to understand your feelings and emotions"*.

- *Personal empowerment*

Sometimes, we actually discover who we are or what we are capable of when we are expected to do things that differ from our inner passion. A participant stated: *"I feel so empowered, né* [sic]*, and when you see people coming in, seeking information you know that you have made an impact, directly or indirectly, because that shows that at least something is happening in the community because people are coming forward"*. Another tried to explain: *". . . I don't know how to put it. . . but for me to be here and to work with them. . . err, sometimes at the end of the day I feel like that I have done something for the youth"*. In performing a task, we get to identify our own qualities, our strengths, and our weaknesses. Mullai (2011) states that the real process of strengths discovery begins with self-reflection and people begin to reflect regularly on the things they do that make them feel strong, and then they develop a new way of thinking.

- *Victim empowerment*

Victim empowerment refers to all actions that are geared towards reducing stress, giving support, educating, and encouraging the victims to take actions that improve their lives (John, 2012). Participants shared a common belief that care provision to youth victims was a great pleasure, since they felt they made an impact on the lives of the victims by empowering victims to take ownership of their lives. One participant shared: *"What I love is and also share, né* [sic], *the information that I have with regards to sexual and domestic violence, like to*

help, young women, young men to be more respectful for their peers and for their partners and to understand where does love come from, né [sic]*."* Another stated: *"I feel great and I feel empowered when somebody picks up the phone and says, you know what, I have been a victim but now I am a survivor".*

- *Job satisfaction*

Job satisfaction is defined as the effective orientation that employees have towards their jobs; it can be considered as either a general feeling about their jobs, or as a related constellation of attitudes about various aspects or facets of the job (Lu, Barriball, Zhang & While, 2011). Participants reiterated their pledge and commitment to nursing as one of the reasons why they were compelled to do their job: *"I love my job, I really love what am doing here. . ." and ". . . I like to help those that cannot help themselves, so that's why am here and am here for my community".* Professional commitment is viewed as a benefit that contributes positively to job satisfaction (Lu *et al.,* 2011).

Discussion

It was evident that providing healthcare to youth victims of violence was regarded as a rewarding experience for nurses, since they felt empowered and satisfied. On the other hand, service delivery to youth victims of violence, in as much as it is a rewarding experience, most often takes its toll on nurses, due to the complexity of the environment, and experiencing multiple stressors in the work environment with very limited opportunities to express the impact of the many daily interactions they are experiencing (Davidson, Ray & Turkel, 2011). During a challenging encounter, stress develops that causes wear and tear on our bodies and minds while trying to adjust to the situation. Unlike physical trauma, nurses providing care to youth victims of violence need practical information, inspiration, and hope (Lerner, 2012).

Fox and Hoelscher (2010) support the notion that economic deprivation and opportunities are motives for individuals to become violent. Khayelitsha is a poverty-stricken township with high levels of unemployment, low household income, under-development, and a lack of an economic base, due to spatial dislocation and historical neglect (Ngxiza, 2011). These conditions are main contributing factors to the increased incidence of violence in the area. Participants felt that the incidence and prevalence of violence in that community were perpetrated by the socio-economic situation of the people. Khayelitsha is a poor community; hence, in an attempt to survive and to make ends meet, the youth are involved in violence. It explains the increased number of youth victims who are attended to at the community health centre, as reported by the nurses.

According to the Newfoundland Labrador Canada (2012), violence and abuse are seen as a pattern of behaviour that is intended to establish power and to maintain control over family, household members, intimate partners, colleagues, or groups. From the experiences of participants who have cared for youth victims of violence, one of the things that they pointed out was the level of gangsterism in the area. Small gangs in the area that are fighting one another contribute to the number of youth victims of violence. Most of the time, violence erupts due to differences that have arisen among the different gangs and is exacerbated by alcohol abuse. The main substance frequently used in this community is alcohol. Drinking is widely seen as behaviour associated with violence and excessive drinking is a cause of violence; alcohol increases aggression and prompts violence (Seekings & Thaler, 2011). Lack of education (illiteracy) leads to difficulties in securing employment. Furthermore, the experiences shared by participants indicated that women were likely to be victims of violence, since they relied on men for support, hence they would tolerate any circumstances for survival.

Participants reported that teenage pregnancy was one of the problems that plagued the youth in society. It had been a challenge in that community for quite some time and it most often resulted from cases of rape and youth who were pursuing men for money. After physical and verbal abuse, young women ended up being pregnant, with the man no longer present to support the children. It placed a great burden on the youth, the families, and the community in general.

Challenges also related to newly qualified nurses and care to youth victims of violence. Nurse leaders emphasised that newly qualified nurses did not know what to expect of delivering care to youth victims of violence (under-prepared) (French et al., 2011). The situation was further challenging in that staff shortages were experienced. Staff shortages impede the nurses' ability to provide quality care (Bégat, Ellefsen & Severinsson, 2005).

Working with youth victims at the community health centre in Khayelitsha was a challenge for many of the nurses. The youth were found to be ill-mannered, some due to the effect of excessive alcohol consumption, and some due to getting impatient when they had to wait their turn to be attended to, while the escorts who accompanied the victims also threatened nurses at the centre.

There were, however, rewarding experiences of nurse leaders delivering care to youth victims of violence. Participants stated that working with youth victims of violence was also an eye-opening experience. They became more aware of themselves and the world of the victims and, hence, their view of health, illness, and victims of violence changed. There was a general sense of achievement and growing from a novice into a true professional. It was also rewarding and empowering when victims acknowledged the little acts of care by the nurses

during their time of need. Participants felt they had an impact and it also boosted personal morale. Many of the participants expressed their satisfaction while working with youth victims of violence, since they felt they were contributing to society. One realises that despite the many challenges they face, like in any other job, they enjoy what they are doing.

Limitations of the study

Many studies have been carried out about experiences of nurses delivering care to patients with different ailments, but this is a relatively new area of research with little published material; therefore, not enough information is available for the purpose of comparing findings.

Recommendations

Violence has an enormous and cascading effect in communities where it occurs. In order to prevent violence and its effects, nurse leaders should look beyond the individual to understand the nature and experience of those affected, either directly or indirectly (Aisenberg & Herrenkohl, 2008). Understanding the socioeconomic factors would assist the development of strengths-basted prevention programmes that address the context of individual risks. Engagement between community leaders and nurse leaders is important, since this would enhance collaboration in supporting victims of violence. Nursing education and training programmes should also prepare nurses for the challenges and expectations of the community to be supported.

Conclusion

Health care delivery to youth victims of violence is a challenging, as well as a rewarding, experience. Improving the wellbeing of nurses will improve the health outcomes of youth in their care and invariably benefit the general health of the community. Nurse leaders need support to carry out their duties and improve the outcomes of their care.

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